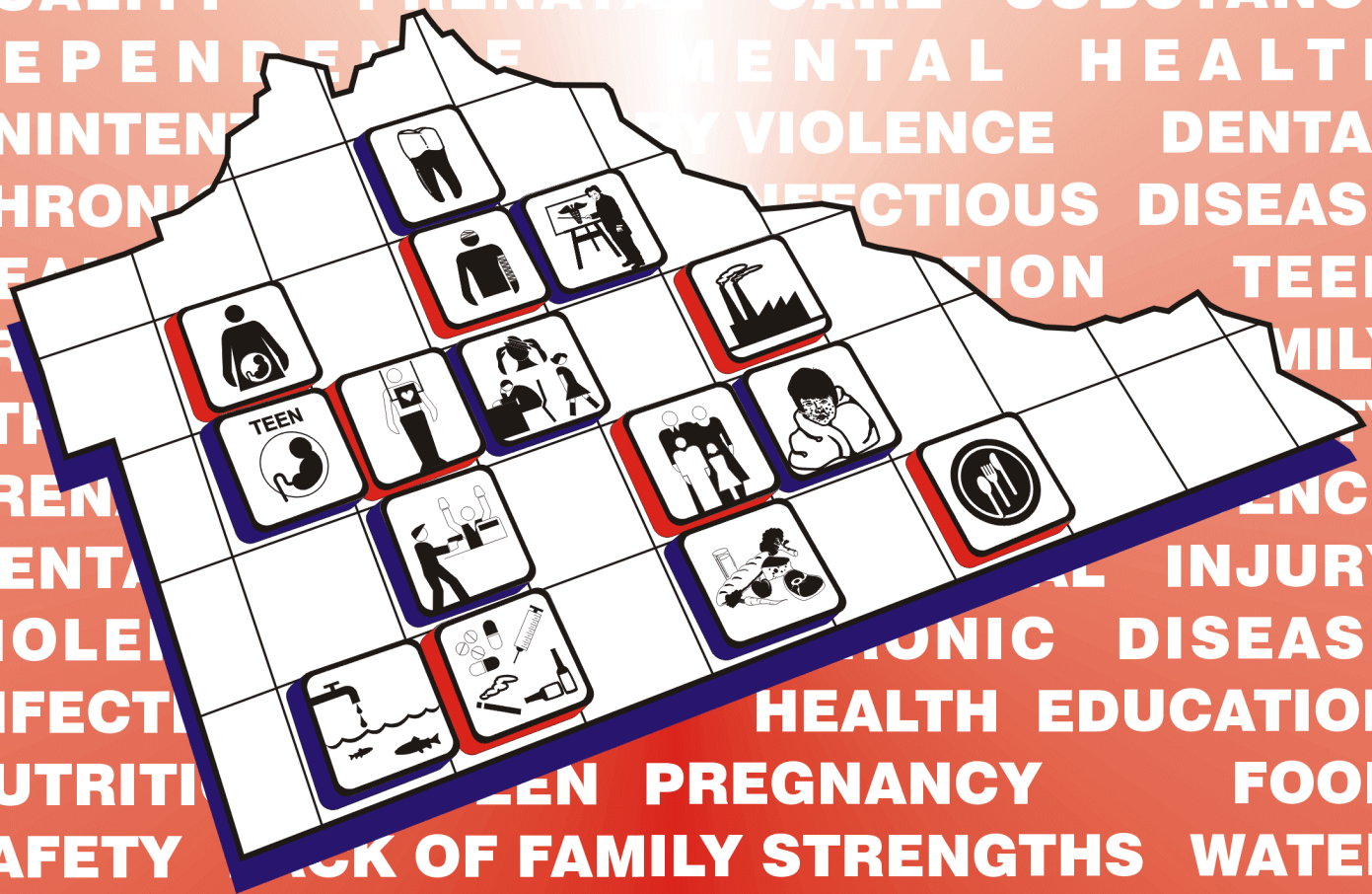
Strategies to Improve Access to Care

A PLAN FOR THE THURSTON COUNTY COMMUNITY

DECEMBER 1999



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OVERVIEW

Thurston County has reached a point where primary medical and dental care is not accessible to all in need. There are many resources in our community, but the safety net is stressed and far too many individuals are falling through the cracks.

In January of 1999, the Thurston County Board of Health reconvened the Community Health Task Force to examine access to primary medical and dental care, find solutions to access issues, and begin implementation of the solutions.

Background

Thurston County is a growing community with a relatively stable economy and high quality of life. The County has been one of the fastest growing in the State since the 1960's, exceeding Washington's overall rate of growth.

- Individuals 35-44 years of age comprise the largest age group in the population, but the elderly are the fastest growing segment of the population.
- Service sector jobs have provided the greatest overall increase in jobs recently in Thurston County, but government remains the largest employer.
- The Thurston County population, as a whole, is healthier than the rest of the national population.

The Thurston County Board of Health convened the Thurston County Community Health Task Force in May of 1994 and gave them the charge to identify, assess, and prioritize conditions that are considered risk factors or that directly affect health and consider responses or strategies to modify each unhealthy condition. The Task Force divided the conditions into three categories: Clinical, Environmental, and Social and ranked the conditions and proposed strategies resulting in the development of 14 priority areas.

For each priority area the Task Force identified a Convener and collaborators from the Thurston County Community and established action plans. The Task Force published their findings in the 1995 report, "Strategies for a Healthy Future." Their efforts resulted in the formation of a number of Community Coalitions that continue to work on Strategies for a Healthy Future.

The Task Force identified access to health care, as an issue in 1994, but did not address it because they felt pending health care reform legislation would solve the problem. The State Legislature rescinded health care reform in 1995, leaving access to care unresolved. Health care access issues have worsened over the past few years.

Providence St. Peter Hospital and the Community Care Clinic operated by Providence have provided medical and dental care for the uninsured in our community for 17 years. Growth in the Thurston County population combined with significant reductions in hospital revenue over the past few years, which is anticipated to continue to decline, has stretched the current safety net to a breaking point. Providence does not solely own the access to care problem -- the Thurston County community does. Community partners must work together to find a solution.

Process

The Community Health Task Force evaluated data that described the access problem, examined barriers, brainstormed possible solutions, and established criteria to evaluate solutions. Task Force members ranked the solutions and determined three as viable options for improving access to care: increase clinical capacity, increase access to insurance, and improve access to dental care for children. They also recognized a need for advocacy to legislators, providers and the public to assist in implementing the solutions.

The Task Force formed four subcommittees to focus on specific solutions that provide a viable and affordable approach. The four subcommittees, Clinic Expansion, Insurance Access, Child Dental Access, and Advocacy considered many aspects of the solutions. Principles expressed in recommendations reached by the Subcommittees and Task Force include:

- Building on programs that work.
- Starting small and building success.
- Maximizing existing resources.
- Strengthening existing relationships.
- Expanding local capacity.

Description and Viability of the Existing Safety Net

The Thurston County medical and dental safety net is comprised of private initiatives and informal networks whose capacity is insufficient. There are concerns that the private safety net is threadbare, at best, despite a strong economy. A significant economic downturn could stress the system beyond its limits making the access problem a crisis.

Hospital emergency rooms are the first line providers for the safety net. Both Thurston County hospital emergency rooms see a significant number of uninsured patients. They are an expensive place to provide care and a poor place for continuity of care. In addition, the Providence St. Peter Hospital (PSPH) Family Practice Residency Program manages about a 100 high risk births a year that were formerly cared for by the Providence St. Peter Hospital Perinatal Clinic. The Residency Program had to hire two OB/GYN physicians to handle the cases. The Community Care Medical and Dental Clinics function as important parts of the safety net. The number of patients they see has grown to a point that far exceeds their capacity. The Community Care Medical Clinic provides only urgent treatment and referral. Waits for emergency dental care can be as long as 8 weeks for adults. Some providers in the Community are caring for a disproportionate share of the low income, uninsured and underinsured clients. Individual medical and dental practitioners have traditionally called on one another to provide services for those in need, however fewer are able to do so in the ever-changing health care system. Local nurse advice lines that provide physician referral services have data illustrating the difficulties in finding a physician especially if you are an adult who is uninsured or covered by Medicaid. The informal systems in place no longer work to assure access to care for all.

The Community Care Medical and Dental Clinics are supported by funding and staffing from Providence St. Peter Hospital, the St. Peter Hospital Foundation, a variety of other state and local funding sources, and volunteer staffing from the medical and dental communities. The clinics provide care to individuals who have no source of medical or dental insurance or care.

TASK FORCE CONCLUSION ABOUT ACCESS TO MEDICAL AND DENTAL CARE

After examining the data and current system and extensive discussions, the Task Force members reached the conclusion:

"Primary medical and dental care needs are not being met for portions of the Thurston County population, including the uninsured and the under-insured."

The Task Force focused their efforts on searching for ways to improve the situation.

RECOMMENDATIONS: WHAT SHOULD BE CHANGED, SUPPORTED, OR STARTED?

The Task Force, after careful consideration of available data, believes the following recommendations will work toward improving access to care issues in the Thurston County Community:

Clinic Expansion

The Task Force recommends the Thurston County Community actively pursue a Federally Qualified Health Clinic (FQHC) satellite to provide primary medical and dental services.

The Community should implement a Request for Qualification (RFQ) process to evaluate interested providers. The RFQ should address the following at minimum:

- How the clinic will gain local provider support including primary and specialty care.
- How the clinic will address issues of a variety of cultures in a competent and sensitive manner.
- How local input will be sought and incorporated into clinic operations.
- How the provider will work with other local resources.
- How the proposal will provide for continuity of care.
- Information about sustainable and feasible funding (sliding fee schedule, cost effective) for the proposal.
- Information about sustainable and feasible staffing (efficiency and local collaboration) of the proposal.
- How the proposal will assure increased access to medical and dental care.

A Federally Qualified Health Clinic is part of a clinic network recognized by the Federal government as one providing care to uninsured and underinsured using a sliding fee schedule. They can provide the care because they receive cost- based reimbursement from Medicaid and Federal 330 funds. The patient mix is 1/3 Medicaid, 1/3 sliding fee schedule, and 1/3 other (insurance, grants, etc.)

Insurance Access

The Task Force recommends the Thurston County Community increase access to health insurance by using an approach that mirrors that of the CHOICE Regional Access Program. Any program should at minimum:

- Provide a case management and outreach resource to inform underinsured and uninsured about services.
- Market Basic Health Plan, Healthy Options, and Children's Health Insurance Program (CHIP). Information suggests that as many as 75% of the uninsured in Thurston County are eligible for existing programs.
- Use outreach to let people know they are eligible for services.
- Provide clients with application assistance and ongoing case management to retain enrollees and ensure ongoing coverage and payment resources for those enrolled.

The CHOICE Regional Access Program is an outreach program for enrolling low-income clients into Basic Health Plan, Medicaid Fee for Service, or Healthy Options. Their ongoing case management program has kept 81% of their clients enrolled in health insurance over a three-year period.

The CHOICE program is experiencing a high demand for services. Without additional resources, the existing program cannot meet current demands. Funding for a portion of the program is threatened in March of 2000 so significant additional resources will have to be found to meet the Task Force's recommendations.

Dental Care for Children

The Task Force recommends the Thurston County Community support the implementation of the Access to Baby and Child Dentistry Program (ABCD) in Thurston County and increase the likelihood of the acceptance of the program by the Thurston/Mason Dental Society by:

- Requesting the Health Department explore staffing, cost, and potential revenues of the program.
- Convening a small group of Dental Society members to work with DSHS Medical Assistance Administration staff, Thurston County Public Health and Social Services Department staff, Community Care Dental Clinic staff, and CHOICE staff to obtain information to prepare for ABCD implementation.
- Exploring funding sources, including the Washington Dental Foundation.
- Collecting qualitative information from dentists in Spokane about their experiences with the ABCD program for the Thurston-Mason Dental Society newsletter, one-on-one conversations, and Thurston-Mason Dental Society meetings.
- Soliciting a speaker from the University of Washington School of Dentistry with ABCD expertise for the Thurston-Mason Dental Society educational meetings.
- Inviting a Spokane ABCD Dentist to come to Thurston County to present an overview of the program and to share Spokane's experience.

The Access to Baby and Child Dentistry Program (ABCD) was developed and piloted in Spokane County. The program is a collaborative effort of the local dental society, health district, Medical Assistance Administration and University of Washington to get Medicaid eligible children into care early and keep them cavity free. This successful and national award-winning program increases early preventive dental care for children under six years of age.

Advocacy

The Task Force recommends that each of the three solutions should include an advocacy component targeted at affected parties including providers, funding sources, legislators, and the public. The audiences to target are first the medical and dental providers, second the FQHC potential partners, and the public.

IMPLEMENTATION PLAN AND TIMELINE

The Task Force recognizes other agency agendas, funding sources and timelines may affect the implementation timeline of the Task Force's recommendations.

- *United Way* funding cycles are every 2 years; the next allocation period begins March 2000.
- *Washington Dental Service Foundation* has quarterly funding cycles, the next applications are due 12/31/99. Funding ranges from $5,000 to $40,000.
- *Building infrastructure:* Thurston County has sold the building which houses the Thurston County Public Health & Social Services Department and the Community Care Medical Clinic. Both organizations will move from the current location at 529 West 4th Avenue in Olympia to an undetermined location or locations. The final location will be known by March 2000, and the move will take place between May and September of 2001.
- *Medicaid Administrative Match* funds are available for identifying and supporting individuals eligible or potentially eligible for Medicaid from the federal agency Health Resources and Services Administration (HRSA). Matching funds can be 50% or 75% of the cost of services depending on the circumstances. Government agencies can contract directly for services (e.g., local, state, schools). HRSA currently allows subcontracts with non-governmental agencies. Thurston County currently has a subcontract with Providence St. Peter Hospital Community Care Clinic, CHOICE Regional Health Network receives Medicaid Match Funds through a subcontract with the Pacific County Health Department. The subcontracting option is at risk of discontinuation.

- *Community Development Block Grant*: Thurston County Commissioners can sponsor one application per year as part of a competitive pool for funding. The County cannot use the funds for regular government operations or ongoing responsibilities of general local government. The County could use the funds to support a collaborative approach to improve access to primary care. The funds are most often used for capital outlay or building space. The funding cycle is yearly, with grant applications due the fall of each year.

- *Other funding sources*: Research is necessary to locate other potential public and private funding sources. It is important to coordinate applications to decrease the possibility of competition among priorities for the same monies.

Task Force Subcommittees Timeline for Implementing Recommendations

The Task Force has formed an Implementation Subcommittee that will begin work on implementation strategies and actions in January of 2000. The subcommittee is a subset of the entire Task Force and will call upon the expertise of others as necessary during implementation. The entire Task Force will be kept informed by mail and/or periodic meetings throughout implementation.

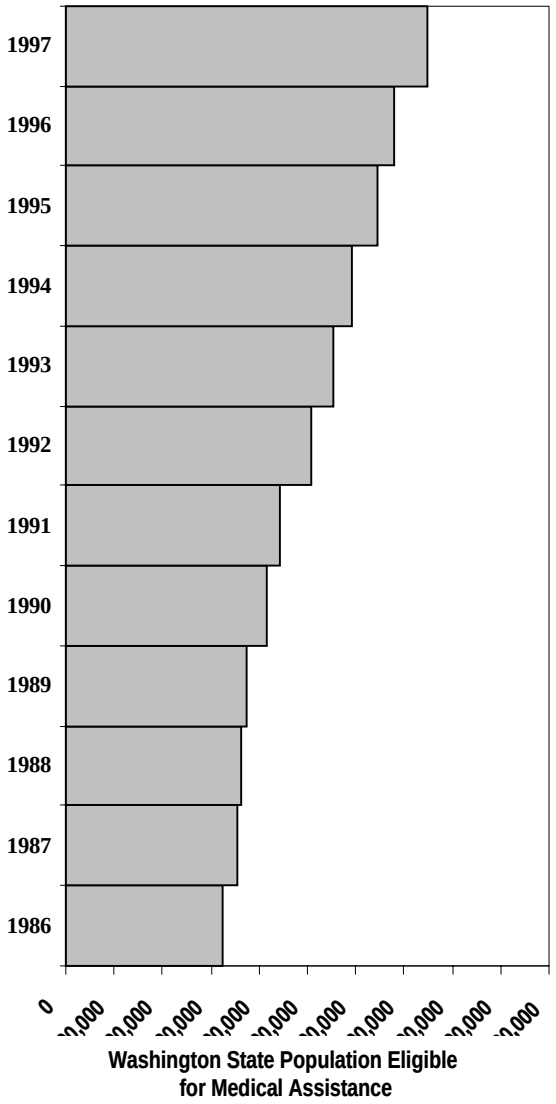
Time Line	Action Necessary
December 1999	**ABCD**: Continue exploring dental provider support for implementation; form a task force of Dental Society members and invite the University of Washington School of Dentistry to the Dental Society meeting. **Clinic Expansion**: Research steps necessary for Federally Qualified Health Clinic expansion including staffing, building, budget, and board. **Insurance Access:** Establish realistic budget and staffing plan **Advocacy:** Generate provider support for FQHC satellite expansion.
January 2000	**ABCD**: Continue exploring dental provider support for implementation; define agency roles. **Clinic Expansion**: Establish Task Force subcommittee; begin Request for Qualification process. **Insurance Access:** Define agency roles and necessary budgetary support. Establish Task Force subcommittee. **Advocacy:** Generate provider support for FQHC satellite expansion.
February 2000	**ABCD**: Establish definitive provider support and agency roles. **Clinic Expansion**: Continue Request for Qualification process. **Insurance Access:** Explore funding sources for program. Explore possible expansion of outreach sites and agencies. **Advocacy:** Generate provider support for FQHC satellite.

Time Line	Action Necessary
March 2000	**ABCD**: Develop funding proposals and training plan. **Clinic Expansion**: Evaluation of Request for Qualification (RFQ) by subcommittee. **Insurance Access:** Explore funding sources for program. Explore possible expansion of outreach sites and agencies. **Advocacy:** Generate public support for FQHC satellite.
April 2000	**ABCD**: Establish funding and agency contracts / memorandums of agreement. **Clinic Expansion**: Subcommittee evaluates Request for Qualification. **Insurance Access:** Design pilot project for Thurston County Health Department. **Advocacy:** Generate public support for FQHC satellite. Develop fundraising support from local private foundations.
May 2000	**ABCD**: Begin client outreach **Clinic Expansion**: Begin work with Federally Qualified Health Clinic. **Insurance Access:** Begin pilot project at Thurston County Health Department. **Advocacy:** Generate public support for FQHC satellite. Develop fundraising support from local private foundations.
June 2000	**ABCD**: Begin matching clients with dentists. **Clinic Expansion**: Work with Federally Qualified Health Clinic staffing, building, budgets, etc. **Insurance Access:** Pilot project at Thurston County Health Department. **Advocacy:** Generate public support for FQHC satellite. Develop fundraising support from local private foundations.
July 2000	**ABCD**: Program fully implemented. **Clinic Expansion**: Work with Federally Qualified Health Clinic. **Insurance Access:** Pilot project at Thurston County Health Department. **Advocacy:** Present FQHC plan to providers and community.
August 2000	**ABCD**: Program fully implemented. **Clinic Expansion**: Work with Federally Qualified Health Clinic satellite. **Insurance Access:** Expand pilot project to other sites. **Advocacy:** Continue advocacy for recommendations.
September 2000	**ABCD**: Program fully implemented. **Clinic Expansion**: Work with Federally Qualified Health Clinic satellite. **Insurance Access:** Pilot project at other sites. **Advocacy:**

Time Line	Action Necessary

October 2000	**ABCD**: Program fully implemented. **Clinic Expansion**: Work with Federally Qualified Health Clinic satellite. **Insurance Access:** Pilot project at other sites. **Advocacy:**
November 2000	**ABCD**: Program fully implemented. **Clinic Expansion**: Open Federally Qualified Health Clinic satellite. **Insurance Access:** Conduct evaluations of pilot project. **Advocacy:**
December 2000	CELEBRATE!

1999 TIMELINE - THURSTON COUNTY COMMUNITY HEALTH TASK FORCE



JANUARY 1999 Reconvene Community Health Task Force, Provide information about background, accomplishments, charge from the Board of Health, job description. Identify data needs.

FEBRUARY 1999 Identify leadership and organization, introduce staff, and determine what success will look like. Hold discussion about Barriers to Access: Players - Consumer: Older adult; Consumer with language barrier; Provider: Dentist. Provider: Physician, Purchaser: Small Business. Identify barriers to access and data points.

MARCH 1999 Discussion about Barriers - Consumer - Hospital/Health System Administrator, Public Purchaser, and Insurance Company. Identify barriers to access and data points. What will success look like? How will the Task Force know when they are finished? Identify key themes of Barriers to Access.

APRIL 1999 Data presentations including demographics, health status, behavior risk factor surveys, health care utilization, and medical and dental health insurance. Discussion of "Models that Work".

MAY 1999 Planning assumptions discussion. Present the expenditures of the existing safety net. How do we quantify the need in Thurston County.

JUNE 1999 Presentation and discussion of preliminary results of the Provider Survey. Formulate hypothesis "Needs for primary medical and dental care are not being met for portions of the population, including the uninsured and the under-insured." Hold a brainstorming session for solutions to access issues. Identify criteria used for selecting solutions.

JULY 1999 Present the list of 42 possible solutions. Develop and come to consensus about criteria used for selecting solutions to access issues.

AUGUST 1999 Present results of the solutions matrix exercise. Form subcommittees - Clinic Expansion, Insurance Access, Dental Access for Children, and Advocacy.

SEPTEMBER 1999 Hold first subcommittee meetings: Clinic Expansion - Evaluate solutions and determine which are feasible, fundable and culturally competent; Insurance Access - Develop a plan to expand insurance access to eligible Thurston County residents; Dental Access for Children - Evaluate the concept of implementing a program like Spokane's ABCD Dental Program and determine if a similar program could be developed for medical access issues; Advocacy - Develop an advocacy plan directed at elected officials and the public to impact the legislative agenda concerning programs that affect access to care of low income Thurston County residents.

OCTOBER 1999 Hold second subcommittee meetings and develop draft action plans. Present subcommittee results to the Task Force.

NOVEMBER 1999 Complete the final report of the Thurston County Community Health Task Force - Access to Primary Medical and Dental Care.

DECEMBER 1999 Present the final report of the Task Force to the Thurston County Board of Health.

Sources: Washington State Office of Financial Management and Department of Social and Health Services

INFORMATION CONTRIBUTING TO THE TASK FORCE'S DECISIONS

Scenarios

To identify barriers to care and view the issue from several perspectives Task Force staff and members presented a series of vignettes (Appendix A) to Task Force members. The vignettes described medical and dental access issues from the perspective of a variety of stakeholders/consumers. The vignettes included:

- Consumers: an older adult and a family with language barriers
- Providers: a dentist, a physician, a hospital/health system
- Purchasers: a small business owner, public purchaser
- Payer: an insurance company.

Task Force members identified key themes around barriers to access from the vignettes and agreed they presented a depressing picture.

- Cost of the System is a Barrier.
  - Those within the system see it as not adequately funded.
  - Is there a lack of resources or maldistribution of the resources?
- Complexity of System
- Lack of Culturally Competent Care
- Language, education, and expectations.
- Ongoing versus episodic care
- No systematic investment in prevention.
- Rising consumerism and declining resources

DATA

Task Force staff prepared a data book (Appendix B) addressing demographics, health status, Behavior Risk Factor Survey, health care utilization, health insurance: medical and dental, and the health care delivery system for Task Force members to use in their decision making process. The book contained local, state, and national data.

Thurston County Demographics

- Thurston County is the eighth fastest growing county in Washington State with a population of 205,500 predicted by the year 2000.
- The racial and ethnic makeup of Thurston County is slowly becoming more diverse. Eighty-eight percent of the population is Caucasian, 4% Hispanic, 5% Asian, 2% Black and 1% Native American.
- Baby boomers make up the largest population segment, with the elderly one of the fastest growing segments of the population.
- Service sector jobs are forecasted to increase by 144% between 1990 and 2020.
- Thurston County residents living at or below the federal poverty level include 42% at 0-17 years of age, 31% at 18-64 years of age, and 27% at 65-99 years of age.

Members noted it appears service sector jobs will grow at a faster rate than the population while construction and manufacturing will grow at the same rate as the general population. Service sector jobs such as hotel, motel, restaurant, and retail, are often held by the working poor and are generally low paying jobs that don't offer health care benefits.

Health Status

For nearly every health indicator, including leading causes of death, we mirror the State of Washington. As a whole, Thurston County is very healthy, and fares better overall than the nation.

Health Challenges for Thurston County include:

- Rates of death to women from Chronic Obstructive Pulmonary Disease including asthma have increased over the past 15 years and are now the same for men and women.
- Thurston County children were 2-3 times more likely to have dental cavities, rampant and untreated cavities, lack sealants, or need treatment or urgent treatment.
- Vaccination rates in Thurston County are similar to the State except for Measles, Mumps, and Rubella, which decreased between 1993 and 1998. The overall vaccination rate in Thurston County has improved over the past five years. In 1993, 49% of children at age two were fully vaccinated. In 1998, 61% were fully vaccinated. Pertussis is the most commonly reported vaccine preventable disease in Thurston County.

- Few low birth weight babies are born in Thurston County. Over eighty percent of pregnant women receive prenatal care in the first trimester. One problem area for pregnant women is smoking – Thurston County has a higher rate than the State. Maternal child health issues are sensitive to socioeconomic factors, unintended pregnancy tends to occur more frequently among low income women with less than a high school education.

Behavior Risk Factor Survey

The Behavior Risk Factor Surveillance System (BRFSS) is a random digital dial telephone survey conducted annually across the nation. Of the total number of the sample selected from Washington State, Thurston County accounts for about 150 surveys per year. In 1996, Thurston County was able to find funding to complete the BRFSS for 500 county residents. One limitation of the BRFS is that only those who have a telephone and speak English are included in the survey. Ninety-eight percent of Thurston County residents have a telephone so the survey may not have included some of the lowest income residents. Selected results for the 1996 Thurston County BRFS follow:

- Twelve percent of residents reported they have no health insurance, and 20% have Medicare. Most of the uninsured are young adults. Ten percent of residents said they could not see a doctor in the past 12 months because of cost.
- Sixty-five percent of respondents indicated they work for wages.
- Fifty-three percent of county residents have smoked at least 100 cigarettes in their lifetime. Thirty-four percent reported they smoke everyday compared to 24% for the State.
- Eighty-two percent of residents surveyed reported they had a usual source of medical care while 16% said they did not. More men than women had no usual source of medical care.
- Sixty-one percent of residents surveyed are overweight and 24% are obese by standards set by the Centers for Disease Control and Prevention. Forty-three percent said they are trying to lose weight.
- Twenty-six percent of residents surveyed said they exercise five or more times per week.
- Eighty-seven percent of women surveyed reported they had a Pap smear in the past three years.
- Most residents (54%) receive their health care in the physician's office or clinic. Twenty-two percent receive their care from Group Health Cooperative and 7% from military health centers.
- When asked why they have not seen a medical provider in the last year, 52% of those surveyed reported they have not needed to see a medical provider. Seventeen percent of those responding said they have not been to a medical provider because they cannot afford care, 10% said that their previous physician is not available, and 6% do not know.

The Task Force expressed concern about whether the statistics for individuals having insurance include those that use the Indian Health Service. If individuals accessing Indian Health Services are included there may be many who report having insurance that have virtually no benefits. Health benefits for Native Americans living on the reservation can be extensive, but if they live off the reservation, the only covered benefit is a clinic visit. Lab tests, x-rays, and medications are not covered.

Health Care Utilization

The Task Force reviewed information from two reports concerning local health care utilization, the 1996 Emergency Room Assessment Project and the 1998 Community Care Clinic Report and found:

- Clients seen at the Community Care Clinic often have serious illness because they seek care late. Even though the clinic is set up to treat and refer clients many of those with chronic illness return multiple times. Establishing a medical home for Community Care Clinic patients can be difficult.
- Most clients of the Community Care Clinic are from Thurston County. Working poor women make up a large percentage of the clinic's clientele.
- The main diagnoses seen at the Community Care Clinic include mental health and substance abuse, hypertension, Type II diabetes, respiratory problems, skin disorders, and infections. Diagnoses vary by year and type of volunteer medical provider available.
- The 1996 Emergency Room Assessment project showed that equal numbers of men and women visit the emergency room. Individuals age 25-44 years visited the emergency room most often.
- Injuries were the number one reason individuals sought care in the emergency room. The typical profile of an emergency room patient was a female with Medicaid coverage, 25-44 years of age, with a sprain, strain, abrasions or other injury. The profile of the typical patient seeking care in the ER suggests domestic violence.

Health Insurance: Medical and Dental

Task Force Staff were unable to find much data about health insurance specifically for Thurston County. Most of the data sources were specific to the state or nation. The Task Force found:

- Twelve percent of Thurston County residents are uninsured and many more are underinsured.
- Lack of insurance correlates strongly with poverty. People choose not to purchase insurance because their incomes are low or they perceive their health risk as low.
- Individuals unlikely to have medical coverage and even less likely to have dental coverage are individuals who are self-employed, work in a low wage job, work part time, or work for a small business.
- Most employees do not seek health insurance on their own if an employer does not offer it as a benefit.
- Fifty-two percent of Washington residents receive health insurance from employers, 31% have publicly sponsored coverage, and the remaining 17% are on their own. Eleven percent of the 17% who are on their own are uninsured.
- Increasingly employees are turning down health benefits due to the high cost, higher employee contributions, and decreased benefits.

Task Force members searched unsuccessfully for information about what portion of the Thurston County community has only catastrophic coverage or are underinsured, and how many who have insurance do not use it because they cannot afford the co-pay. The total number of uninsured increases while the percentage of uninsured decreases due to growth in the county. Task Force members noted, there are 22,000 people in Thurston County who do not have health insurance coverage. Estimates are that about 3- 4% of county residents have Basic Health Plan for medical coverage and less than 50% of residents have dental coverage.

Health Care Delivery System – Provider Availability

It was the perception of the Task Force that few medical and dental providers had practices that were open and accepting new patients. To determine if Thurston County was a medically underserved area Task Force staff worked with staff from the Department of Health, Office of Community and Rural Health to design and conduct a comprehensive survey of medical and dental primary care providers in Thurston County (Thurston County Primary Care Medical and Dental Provider Survey, August, 1999 is available from the Thurston County Public Health and Social Services Department, Epidemiology, Assessment and Planning Section). Findings of the surveys follow.

Thurston County Primary Medical Provider Survey Results: June 1999

Responses:
Include providers responding to the mailed out survey; Physicians (Family Practice, OB/GYN, Pediatrics, General Internal Medicine), Physician Assistants, Nurse Practitioners, and Certified Nurse Midwives.

Retirement:

- Three percent or 8 providers plan to retire in the next 5 years

Primary versus Specialty Care:

- Ninety-nine percent or 211 providers said over 95% of their practice is devoted to primary care

Hours Available:

- Fifty percent of providers are not available to see patients on any given day of the week, Monday through Friday.

Additional Location:

- Five-percent or 11 providers have an additional office location.

Payment Sources:

- Thirty-two percent or 69 providers indicated less than 5% of current patients pay with Medicaid.
- Forty-four percent or 94 providers offer a sliding fee schedule, ability to pay basis or prearranged fee to patients
- Thirty-six percent or 76 providers have less than 5% of current patients pay using sliding fees, ability to pay, or prearranged fees during the most recent fiscal year.
- Sixty percent or 129 indicated less than 5% of care was not compensated in any way during the most recent fiscal year.

Languages:

- Fifteen percent or 32 providers fluently speak a language other than English. Of those, 9% (20) speak Spanish, one speaks Vietnamese, and two speak Cambodian.
- Forty-three percent or 92 providers have staff that speaks a language other than English. Of those, 20% (45) speak Spanish, 10 speak Vietnamese, 7 speak Cambodian, 1 speaks Laotian, 1 speaks Russian, and 1 speaks Ukrainian.

New Patients:

- Sixty-five percent or 139 providers are accepting new patients, 35% (76) are not accepting new patients.
- Fifty percent or 107 providers are accepting new Medicaid patients. Forty-nine percent or 105 providers are not accepting new Medicaid patients.
- Fifty-eight percent or 124 providers are accepting new Healthy Options patients. Forty percent or 86 providers are not are not accepting new Healthy Options patients.
- Fifty-one percent or 110 providers are accepting new Medicare patients. Forty-seven percent or 100 providers are not accepting new Medicare patients.

Thurston County Primary Dental Provider Survey Results: June 1999

Responses:

Include providers responding to mailed out survey; Dentists (general practice, pedodontics).

Retirement:

- Nine percent or seven providers plan to retire in the next 5 years.

Primary versus Specialty Care:

- Seventy-six percent or 62 providers indicated over 95% of their practice is devoted to primary care.
- Nineteen percent or 20 providers indicated a portion of their practice is devoted to specialty care, including endodontics, orthodontics, prosthodontics, oral surgery, peridontics, and cosmetics.

Hours Available:

- Fifty-six percent or 46 dentists are not available to see patients on Friday
- Twenty-three percent or 19 dentists are not available on Monday
- Nine percent or 7 providers are not available on Tuesday
- Eighteen percent or 15 providers are not available on Wednesday
- Eleven percent or nine dentists are not available on Thursday.

Additional location:

- Nine percent or seven providers have an additional office location.

Payment Sources:

- Sixty-six percent or 54 providers indicated less than 5% of their current patients pay with Medicaid.
- Twenty-five percent or 20 providers offer a sliding fee scale, ability to pay basis or prearranged fee to patients
- Seventeen percent or 14 providers indicated less than 5% of their current patients pay using a sliding fee scale, ability to pay basis, or prearranged fees during the most recent fiscal year.
- Sixty-four percent or 52 providers said less than 5% of care was not compensated in any way during the most recent fiscal year.

Languages:

- Sixteen percent or 13 providers fluently speak a language other than English. Of those four speak Spanish, two speak Vietnamese.
- Six percent or five providers have staff that speaks a language other than English. Of those, four speak Spanish.

New Patients:

- Ninety-three percent or 76 of the providers are accepting new patients. Seven percent or six of the providers are not accepting new patients.
- Twenty percent or 16 of the providers are accepting new Medicaid patients. Eighty percent or 65 providers are not accepting new Medicaid patients.
- Twenty-one percent or 17 providers are accepting new Healthy Options patients. Seventy-seven percent or 62 providers are not are not accepting new Healthy Options patients.

Age of Dentist:

- Eighty-six percent or 66 providers are less than 55 years of age.
- Ten percent or eight providers are 55-59 years of age.
- Three percent or two providers are 60-64 years of age.
- One percent of providers is over 64 years of age.

The survey was an invaluable tool in determining the capacity of the primary care medical and dental systems in Thurston County. In our search for solutions to medical and dental access problems, we found that the designation of Health Professional Shortage Areas in the county would be an asset when looking for Federal funding enhancement. As a result of the surveys the Washington State Department of Health has submitted requests to the Federal government for two designations: the Downtown Olympia Low-Income Primary Care Health Professional Shortage Area and the Thurston County Low-Income Dental Health Professional Shortage Area. Thurston County does not presently qualify for a start-up Federally Qualified Health Clinic.

SUGGESTED SOLUTIONS

The Task Force brainstormed solutions and suggested the following potential solutions to address increasing clinical capacity in the County:

Increase Clinical Capacity

- Expand the Providence St. Peter Hospital Community Care Clinics.
- Seek a Federally Qualified Health Clinic - or expansion/satellite of an existing clinic.
- Expand primary care at the Thurston County Health Department.
- Develop a culturally competent medical and dental clinic co-funded by foundations/grants/business and the community.
- Implement an ABCD-like program sponsored by the Dental Society.
- Create a model of community public health and education (prevention) while planning a comprehensive approach.
- Apply for a "Medically Underserved Designation" for Thurston County and recruit for MUD providers.
- Design school-based clinics.
- Examine the role of Providence St. Peter's Family Practice Residency concerning primary care access.
- Recruit Primary Care Providers to the community and establish a charity equity bank (a mechanism to assure an equitable distribution of uninsured and underinsured patients to a voluntary pool of providers.)
- Fund rural health care mobiles or satellites in partnership with four counties
- Apply an ABCD-type program to the medical system with an incentive for physicians participating (CME credit, medical Spanish education, tax credits for his practice). The Access to Baby and Child Dentistry Program (ABCD) is a dental program in Spokane sponsored by the Dental Society, the University of Washington, and DSHS that targets children 0-6 years of age. The program provides case management and education to families, and increased reimbursement to providers as an incentive to take the children as patients.
- Develop a LOTT- type program for primary medical/dental care -- no defined home, but community sponsorship and shared governing structure.
- Develop a community partnership with universities where students provide services and learn at the same time.
- Develop a creative and unique program to meet a special needs population (homeless, or previously incarcerated) to attract grant funding, and help fund the primary care services needed.

Work with Existing Resources

- Develop a consortium of existing services and providers with some centralized 'core functions' such as administration, billing, and access coordination and referral
- Locate support for the expansion of Dr. Clark-Neitzel's affordable, culturally competent model of care (Dr. Clark-Neitzel is a local provider whose practice is about 40% Hispanic clients and many Medicaid patients, and survives financially).
- Assist those in need with finding existing resources (referral/case management functions).
- Contract with provider networks (Memorial Clinic Health Network, Physicians of Southwest Washington, and Pro Health Alliance) to provide primary care. Who would contract for services is not clear.
- Organize medical community to increase access.
- Require a certain percentage of Medicaid patients per provider.
- Advocate for individual providers, large clinic networks, and payors to volunteer to take a percentage of no-pay patients.
- Consider a four-county partnership with Lewis, Mason, Grays Harbor and Pacific.
- Address lifestyle changes and preventive care issues.

Address Financing (including revenues and community support)

- Increase non-governmental (philanthropic) assistance to support uncompensated care.
- Advocate for enhanced federal/state/local funding to raise reimbursement.
- Encourage State to redirect dollars spent on emergency care for the uninsured into clinic-based outpatient care.
- Develop creative approaches to client payment systems.
- Explore a barter system similar to Sound Dollars.
- Change the tax structure to increase government dollars to pay for uncompensated care.

Improve/Increase Insurance Coverage

- Expand insurance access by increasing the "CHOICE Regional Access Program" or develop a similar program and increase Basic Health Plan enrollment.
- *Require* businesses to provide health insurance for employees
- *Encourage* businesses to provide health insurance to their employees
- Provide universal health coverage
- Design a County insurance plan for the uninsured (subsidized by a County tax).
- Integrate existing funds that are currently categorical

Other Solutions

- Increase the economic base to increase the working insured population, which will attract new physicians and dentists to the area.
- Design programs to assist patients in bonding more closely with their physicians.
- Redefine/rethink the problem.
- Involve target populations in planning the solutions to test whether they will work.
- Do nothing.

SOLUTION SELECTION CRITERIA

The Task Force generated a list of criteria to evaluate the solutions. The following were used to determine which solutions to pursue:

- *Provider Support:* Will providers, currently practicing in the area, advocate this solution? An answer of "1" would mean that providers would oppose this solution, an answer of "5" would mean that providers would welcome this solution.
- *Provides for Continuity of Care:* Will the patient have continuous, connected care over time? An answer of "1" would mean no continuity, an answer of "5" would mean great continuity.
- *Sustainable & Feasible Funding and Staffing:* The funding and staffing solution requires a limited amount, if any, voluntary provider time. Answer of "1" would mean that success would depend completely upon voluntary providers, an answer of "5" would mean very limited, if any, dependence on voluntary providers.
- *Increases Access:* Will there be more access than is currently available in the community? An answer of "1" would mean no increase in access, an answer of "5" would mean a great deal more access would be available.
- *Culturally Competent:* Would the solution increase the availability of providers or staff with languages other than English, and awareness and understanding of cultural issues that are different than the dominant culture? An answer of "1" would mean the solution does not increase availability or understanding, an answer of "5" would mean availability and understanding are greatly increased.
- *Efficient /Cost Effective:* Will the solution maximize efforts and minimize duplication; the amount of money put toward the solution would buy more than if the solution were not available? An answer of "1" would mean a costly, duplicative solution, an answer of "5" would mean the dollars were well spend for service not accessible elsewhere.

SOLUTION MATRIX

Task Force staff asked members to rank each solution on a scale of one to five. Total score from all Task Force participants' follows:

Solutions Ranked by Total Score

SOLUTION	TOTAL SCORE	Provider Support	Continuity	Sustainable	Increases Access	Culturally competent	Efficient
Seek a Federally Qualified Health Clinic - or expansion/satellite of an existing clinic	590	93	99	81	111	95	92
Expand insurance access by increasing the "CHOICE Regional Access Program" or developing a similar program, and increasing access to Basic Health Plan	572	103	103	86	105	68	86
A culturally competent medical and dental clinic co-funded by foundations-grants-business and the community	552	85	91	70	98	103	79
Support for the expansion of Dr. Clark-Neitzel's affordable, culturally competent model of care***	520	67	92	72	87	96	78
Apply an ABCD-type program to the medical system and the physician gets something for participating (CME credit, medical Spanish education, tax credits for his practice)**	476	71	86	59	91	72	84
Thurston County receives "Medically Underserved Designation" and recruits MUD providers	470	76	77	70	81	72	67
Expand Providence St. Peter Hospital Community Care Clinics	469	83	74	61	85	74	75
Advocate for enhanced federal/state/local funding to raise reimbursement	464	105	63	66	73	58	71
Examine the role of Providence St. Peter's Family Practice Residency with regard to primary care access	463	96	85	72	68	62	62
Implement the ABCD dental program sponsored by the Dental Society	458	69	81	65	87	54	85
Universal health coverage	449	60	85	64	79	66	70
Expand primary care at the Thurston County Health Department	444	73	66	53	87	87	61
County insurance plan for the uninsured (subsidized by a county tax)	434	66	78	73	80	58	56
School-based clinics	417	60	65	56	73	74	73
Encourage business to give health insurance to their employees	417	74	71	62	67	62	61
Address lifestyle changes and preventive care issues	409	85	50	61	42	72	73
Increase non-governmental (philanthropic) assistance to support uncompensated care	405	84	66	53	64	49	65
Recruit Primary Care Providers to community and establish a charity equity bank*	404	57	74	53	94	58	56

SOLUTION	TOTAL SCORE	Provider Support	Continuity	Sustainable	Increases Access	Culturally competent	Efficient
Develop a community partnership with universities where students provide services and learn at the same time	404	69	54	64	77	62	61
Develop a consortium of existing services/providers with some centralized 'core functions' such as administration, billing, and access coordination/referral	403	62	70	50	68	56	68
Encourage State to redirect $$ spent on emergency care for the uninsured into clinic-based outpatient care	390	73	63	57	61	51	57
Assist those in need to find existing resources (referral/case management functions)	385	78	59	54	53	65	60
Involve target populations in planning the solutions to test whether they will work	384	68	55	53	60	70	60
Fund rural mobiles or satellites in partnership with four counties	382	55	61	52	72	68	54
Require business to give health insurance to employees	382	74	66	59	63	53	54
Individual providers, large clinic networks, and payors voluntarily agree to take a percentage of no-pay patients	369	46	56	54	84	50	65
Develop a creative and unique program to meet a special needs population (homeless, or previously incarcerated) to attract grant funding, and help fund the primary care services needed	366	62	52	46	68	70	48
Create a model of community public health & education (prevention) while planning a comprehensive approach	363	58	55	61	45	61	63
Change the tax structure to increase government dollars to pay for uncompensated care	357	69	56	55	60	43	49
Integration of existing funds that are currently categorical	357	57	61	55	60	48	56
Increase economic base to increase working insured population (which will attract new physicians and dentists to the area)	342	80	48	58	50	37	53
Develop a LOTT- type program for primary medical/dental care -- no defined home, but community sponsorship & shared governing structure.	336	45	50	45	65	60	38
Consider a four-county partnership with Lewis, Mason, Grays Harbor and Pacific	328	48	46	47	55	54	52
Require a certain percentage of Medicaid patients per provider	319	24	64	48	80	40	49
Make patients bond more closely with their physicians	303	65	58	37	38	44	43
Organize medical community to increase access	297	49	48	45	59	41	44

SOLUTION	TOTAL SCORE	Provider Support	Continuity	Sustainable	Increases Access	Culturally competent	Efficient
Contract with provider networks (Memorial Clinic Health Network, Physicians of Southwest Washington, and Pro Health Alliance) to provide primary care (who would contract is not clear)	258	45	46	34	49	34	34
Creative approach to client payment systems	257	44	38	40	40	36	32
Explore a barter system similar to Sound $$	205	30	32	34	36	32	24
Redefine/rethink the problem	164	30	27	27	22	24	27
Do nothing	163	31	21	34	21	21	25

"Models that Work"

The Task Force researched solutions from other areas. Members saw a video about the national program called Models that Work. This program sponsored by the Department of Health and Human Services, Health Resources and Services Administration (HRSA) has a goal to expand local access to quality health care by helping communities replicate, adapt, and sustain innovative and creative award winning models for the provision of primary care services. Models that Work award winners are those that show community responsiveness, innovation, collaboration/integration, measurable outcomes, potential for replication, adaptation, sustainability in other communities, and administrative effectiveness.

Models that Work offers a variety of resources to help communities understand award-winning models from across the nation, and then provide technical assistance from communities that have implemented award-winning solutions.

SUBCOMMITTEES: WHAT DID WE TAKE INTO CONSIDERATION?

Children's Dental Access

PURPOSE:
1. Evaluate the feasibility of an ABCD Dental Program in Thurston County.
2. Evaluate the feasibility of ABCD's use if applied to a medical model.

Recommendations	ABCD Program Participants	ABCD Target Groups	Comments

• Support ABCD program in Thurston County
• Pursue the following to facilitate acceptance by the Thurston/Mason Dental Society:
  • Health Department explore the staffing, cost, and potential revenues to support the program
  • Small group of Dental Society members work with Carrie Moore, Sherrie McDonald, Community Care Dental Clinic staff, and CHOICE staff to get information in preparation for ABCD implementation.
  • Explore funding sources, including the Dental Foundation
  • Gather quotes from dentists in Spokane about their experiences with ABCD that could be used in the Dental Society newsletter, in one to one conversations, or at Dental Society meeting.
  • Solicit U of W speaker with ABCD expertise for the Nov or Jan Dental Society meeting.
  • Invite Spokane ABCD Dentist to come to Thurston County for overview and share Spokane experience.
	Health Department: provides outreach and case management to the target population of Medicaid eligible children age 0–4 years, enroll clients, address barriers to care with clients and their families, and match clients to certified providers.
	Dental Society: recruit providers, oversee provider activities, perform peer review, provide housing and supervision of an "ombudsman" position to help address billing problems between DSHS and providers; assist in identification of access barriers.
	Medical Assistance Administration: fund increased provider rates for specific procedures, track identified clients, resolve program policy and billing issues as they arise, monitor overall project functioning; provide monthly utilization and expenditure report.
	Washington State Dental Association: facilitate bringing together key players and issues in the development of ABCD; promote expansion of the program.
	University of Washington School of Dentistry: develop and conduct provider training and continuing education certification, program evaluation; responsible for technical and procedural consultation regarding enhanced treatment; monthly newsletter for participating dentists.
		Medicaid eligible Children: care up to age 6 i.e.– early exams, preventive guidance, sealant, varnish
		
		Families, especially parents, of children in target group get case management and instruction in dental office etiquette. Ripple effect to siblings with improved dental self -care.
		
		Providers: receive education, training, and certification as ABCD provider. Increased reimbursement for specified procedures, many of which can be delegated to ancillary staff.
			• Roles of ABCD participants may vary by locale and program setup.
			• Program designed to address long-term prevention
			• Potential barriers:
			  • Need 51% of primary care dental providers to participate in order for the program to be viable.
			  • Funding for staff whose jobs would include outreach, case management, recruitment, training, oversight, and billing issues. i.e. the Health Department, Dental Society, or another agency in the area,
			• ABCD program does not address unmet dental needs of adults, nor children >6 yo.
			• ABCD model applied to the medical system is unlikely to be viable, most specifically due to current reimbursement structures.
			  • Potential creative solutions include adapting provider and patient/parent education components via grant funding.

Clinic Expansion Subcommittee

Purpose:
Evaluate several clinic-based solutions for medical and dental access expansion and determine which ones are the most feasible, fundable, and culturally competent.

Recommendation	Community Resources	Target Groups	Comments

• Actively pursue a Federally Qualified Health Clinic satellite with both medical and dental services.
• Implement a Request For Qualification (RFQ) process to evaluate interested providers approach to:
  • Local provider support including primary and specialty care
  • Cultural competency
  • Local input
  • Work with other local resources
  • Continuity of care
  • Sustainable and feasible funding (sliding fee schedule, cost effective)
  • Sustainable and feasible staffing (efficiency and local collaboration)
  • Increase access
	• Providence St. Peter Hospital Community Care Clinics
	• 17 year history in providing medical services to uninsured
	• Dental clinic seen as one of the most successful models in the State
	• Local foundations support
	• Providence Health System's continued interest in providing access and support of a longer term, sustainable solution
	• Excellent medical community with all subspecialties
	• Potential Community Development Block Grant in combination with the Health Department
	• Health Professional Shortage Area designation
	• PSPH Family Practice Residency
	• Dr. Clark-Neitzel's practice
	• Community process with key medical players to provide support
	• Thurston County Board of Health support
	• Large urban area without federal and state dollars for primary care resources
	• Current comprehensive provider survey
	• Health Department resources
	• CIELO Access project
		• FQHC satellite must have balanced resources to be successful:
		  • 1/3 Medicaid
		  • 1/3 sliding fees
		  • 1/3 grants: local, state, or federal
		• Low income, uninsured children, adults and families
			• Thurston County has applied for Health Professional Shortage Area (HPSA) designation for both medical and dental
			• We can start small and add building blocks over time.
			  • FQHC can provide
			  • Federal dollars for care
			  • Cost-based Medicaid reimbursement
			  • Economy of scale for billing, contracts, insurance, and organizational structure
			• FQHC must have 51% governing board members that are consumers
			• Expanding Community Care Clinics, Health Department primary care, or PSPH Family Practice Residency are not feasible
			• Thurston County does not qualify for our own FQHC
			• A locally owned and operated clinic is not feasible due to funding constraints

Increase Insurance Access Subcommittee

Purpose:
Develop a plan to expand insurance access (Healthy Options, Basic Health Plan) to eligible citizens in Thurston County through programs such as the Regional Access Program sponsored by the CHOICE Regional Health Network.

Recommendation	Community Resources	Target Groups	Comments

• Increase access to health insurance using the principles and practices of the CHOICE Regional Access Program.
  • Basic Health Plan, Healthy Options, and CHIP have capacity to cover about 75% of the currently uninsured in Thurston County
  • Outreach is necessary to let people know they are eligible
  • Application assistance and ongoing enrollment case management is necessary to retain enrollees
  • Demand is currently outstripping resources of the CHOICE program
	• Community Action Council has 3-4000 low-income families per month they could impact
	• Community Youth Services has a Youth Employment Program that might partner with CHOICE to work as outreach coordinators and enroll children and families
	• Headstart and Food Bank are other potential outreach sites
	• Thurston County Health Department will be implementing new income assessment procedures that could identify more potentially eligible families
	• Peer-to-peer education works very well: people who have enrolled in programs are great outreach workers
		• Basic Health Plan: families with incomes below 200% Federal Poverty Level
		• Healthy Options: families with incomes below 200% Federal Poverty Level
		• Children's Health Insurance Program (CHIP): children in families with incomes below 250% Federal Poverty Level
			• Regional Access Program Services:
			  • Marketing and advertising
			  • Outreach to community-based organizations
			  • 1-800 number with a live person who facilitates attendance
			  • Application assistance
			  • Enrollment case management
			  • Advocacy
			  • Limited financial assistance
			  • Consumer education

Advocacy Subcommittee

Purpose:

1. Develop an advocacy plan directed toward elected officials and the public at large to favorably impact the legislative agenda as it relates to reimbursement for programs that directly affect access to care for low-income citizens in our community.
2. Advocate for outcomes from each of the other subcommittees: ABCD, Clinic Expansion, Insurance Access.

Recommendation	Community Resources	Target Groups	Comments

• Incorporate advocacy as part of each subcommittee recommendation.
  • Clinic Expansion
  • Insurance Access
  • Children's Dental
• Transmit the Final Report from the Thurston County Board of Health/County Commissioners to state and federal legislators to raise the profile of the Health Care Access issue.
	• Thurston County Community Health Task Force members
	• Location in the state capitol city
	• Member connection to many groups with similar interests and activities
		• State legislators
		• Federal legislators
		• General public
		• Medical and Dental providers
		
		Suggested campaign message:
		The current system is not adequately funded.
			• Potential avenues that might be used for advocacy include:
			  • Speakers Bureau to raise awareness of the access issue and the solutions proposed. Consider going to service clubs and high schools
			  • A "connectivity" network to allow quick information dissemination and action
			  • Presentation of issue(s) to Editorial Board of Olympian, other newspapers, and radio stations
			  • Meet with local legislators, not during legislative session
			  • Hold a Thurston County Health Roundtable developed to provide counsel on local health issues and to screen potential legislative candidates.
			• Concern: how can we staff and support these efforts?

APPENDICES

APPENDIX A. Medical and Dental Consumer Scenarios

Vignette #1: Consumer -- Older Adult

Mr. Olden Grumpy is a 60-year-old recently retired gentleman with long-standing Type II Diabetes. He is new to the area and needs to find a physician but his COBRA benefit ran out a few months ago and he has not yet purchased a private health insurance plan. For his income of $1500/mo. the Basic Health Plan will cost him $306/mo. -- and he "doesn't have that kind of money!" He doesn't know whom to turn to for help with this issue. Up until his insurance lapsed, he had fairly regular health visits but has always found his diabetes hard to control. A few days ago he started running a fever and felt really badly. A call to a local nurse advice line directed him to the Community Care Clinic where he was seen by the ARNP. She started treatment for his infection but felt that he really needed ongoing care by a specialist. She has been unable to find one willing to accept this patient until he has insurance. "Well," the ARNP thought, "if his condition worsens I'll be forced to send him to an Emergency Room to get the specialty care he needs."

Vignette #2: Consumer with Language Barrier

(This was read to the committee first in Spanish, then in English)

A Spanish speaking family has been seeking care in Federal Way at the Group Health clinic although they live in Yelm. The mother of the family does not know there is a clinic in Olympia, nor does she know how her family got the Group Health card (it came in the mail). A translator/advocate is asked to contact her to help divert the family to the Olympia clinic. During this time it becomes evident that the Group Health coverage is no longer active as her husband has lost his job (they do not know this is a benefit of his work) and they are amassing a bill at the Federal Way clinic. The family, in the meantime, has signed up for Temporary Assistance to Needy Families (TANF), but does not realize there are medical benefits included. It takes the translator/advocate ten calls to straighten all this out. She is able to have Group Health apply the Medicaid coupons to the Federal Way bill, and get the family connected with providers in Olympia.

Vignette #3: Provider -- Dentist

The Office Manager of Dr. Newdentist's office, Ms. Happy Smile, shook her head as she got off the telephone with yet another Medicaid eligible person seeking dental care. This 30-year-old woman, Ms. Pain Fulltooth, is seeking follow-up care after an emergency room visit for an abscessed tooth. She has taken antibiotics and pain medication and the tooth has 'settled down' but she knows she needs follow-up care. Ms. Happy Smile does not blame Ms. Pain Fulltooth for being upset. Six weeks is a long time to wait for a dental appointment and getting the word up front that there might be limits to care is probably offensive. "They just don't understand – it's not their fault that Medicaid reimbursement only covers 30% of our fixed overhead. But when the overhead generally runs 70%, it's a losing proposition every time -- especially when we have a 'no-show' and could have had an insured patient in the chair. If it wasn't so cumbersome to deal with state agencies as well, maybe their office could take a few more Medicaid folks every month. And with Dr. Newdentist's school loans and office start-up costs, it's tough to make it all work -- he has to work so fast, he should have roller skates!"

Vignette #4: Physician

Dr. Hypocrites has a busy primary care practice and takes patients with all types of health care coverage: Commercial, Healthy Options, Basic Health Plan, and Medicare. He feels that the reimbursement from these plans, except for Medicare, is adequate for the most part. Today Dr. Hypocrites sees a patient that has recently lost her job and her insurance coverage. He tells Ms. NoMoney that he is happy to see her for a reduced fee until she gets back on her feet. He works especially hard with his established patients to continue to provide care for them when they hit hard times and have no insurance coverage. He takes his share of non-paying patients but must limit the amount in order to maintain a viable office practice. A big problem for his uninsured patients, however, is that Dr. Hypocrites realizes he is only one part of a very large and complex health care system and when these patients need lab work, medications, or a referral to a specialist, Dr. Hypocrites has no way to help them get these.

Vignette #5: Purchaser -- Small Business

Mr. Small Business rubbed his forehead as he looked at the figures one more time. He couldn't believe it! His health insurance rates had just gone up 20% for the coming year. He was told that his work force wasn't getting any younger and now some were getting "age rated" which was making his premium go through the roof. And the insurance broker had tried to explain, once again, the different options -- what a nightmare! -- Point of Service, HMO, PPO, PSN's, Fee for Service, etc. He thought back to the days when his employees and their dependents were fully covered for medical and dental (with company names he could remember and plans he could understand) and he had been able to pay the entire bill -- those days were long gone!! He had to drop dental and vision a few years back, and the most affordable health plan last year had restricted his employees' choice of providers -- which really caused some angry responses. The only way he was going to swing the rate increase this year was to split it with his employees. Given that they are already paying for their own dependents, he felt they just might revolt! If this gets any worse he will have to just give them a certain amount of money a month and tell them to find insurance wherever they can, or drop it all together!

Vignette #6: Consumer – Hospital/Health System Administrator

Ms. Hospital Administrator (also could be Ms. Health System CEO) sat back in her chair and heaved a deep sigh She was preparing a report for her community board and did not know how to do so without sounding pessimistic. "The financial picture just keeps getting worse and worse", she thought. Hospital reimbursement from private and government payers has decreased over 11% in the last 4 years and will get only get worse as the Balanced Budget Amendment continues with its 115 billion dollars of reductions in Medicare payments between fiscal years 1998 and 2002. If only Medicare wasn't 30% of our revenues! Reimbursement from commercial insurance, once the vehicle that helped underwrite the shortfalls from Medicare and Medicaid, has shrunk substantially and no longer makes up the shortfall, but adds to it. Hospital margins/profits to purchase equipment, remodel and subsidize services to the poor are down nearly 75%. "How can we maintain the programs our community has expected of us all these years", she thought to herself "as well as meet the expectations that our facilities will have the latest and greatest technology and treatments." All of this with the backdrop of the public losing confidence in the American health system. "Putting a good face on this picture is going to take nothing short of a miracle!", she surmised and went back to preparing her report.

Vignette #7: Public Purchaser

Ivgot Problems, the head of the purchasing consortium for the State of Rainington, reviewed the legislative briefing for the week. As the person responsible for public health programs; Medicaid, State employees, the Basic Health Plan, Labor & Industries and the prison system, the situation was getting considerably worse and very tough decisions would have to be made. Increasing funding for these programs wasn't likely in spite of the fact that health care inflation is running far higher than general inflation, and the fact that the demographic shift - the so called "Graying of America" is starting to be felt in most programs. Managed Care has managed to moderate (or mask) health care premium increases for a few years, Ms. Problems had to admit, but now double digit rates of increase were back... Funding for Medicaid and the Basic Health Plan is competing for limited state and federal funds. State-funded medical programs currently comprised 12% of the total state general fund spending, but are likely to require 30-45% of the allowable growth in state general fund spending. Initiative 601 and Referendum 49 (impending loss of 470 million in revenues for the next biennium) have made spending increases virtually impossible which leaves several less than desirable options to limit spending; increasing co-pays and premiums, reducing coverage, reducing payments to providers, or reducing the number of covered persons. Ivgot Problems surmised that she was between a rock and a hard place and in a no-win situation.

Vignette #8: Insurance Company

Mr. Arty Actuarial, President and CEO of "We're always there for you" health insurance company in the State of Rainington was bracing himself for the inevitable bad press that would come from this year's premium increases. "People talk about insurance companies being on the downside of the actuarial cycle", he thought, " the best and brightest in his company were convinced that the actuarial cycle isn't even working anymore! Plain and simple, they were hemorrhaging financially - 45 million more in payments, in 1998, than they took in premiums. And they were not alone - every carrier in Rainington was in the same boat."

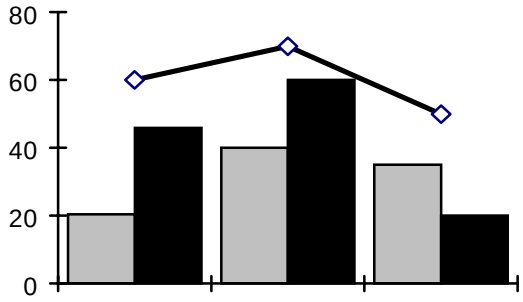
The reasons for these losses, from his perspective, were the huge increases in drug and technology costs, coupled with an exceedingly well informed and aggressive public who want access to everything advertised and found on the Internet. "Also, the competition in the market place has caused us, for the past few years, to under price our premiums so employers will continue to purchase insurance for their employees.

The private insurance market and the "Basic Health Plan" are certainly the most volatile, Mr. Actuarial surmised. Recently, out of financial desperation, large carriers suspended new business in several counties in the state, leaving individuals that wanted insurance coverage no options. With only a three month waiting period, he had heard of story after story of pregnant women signing up during pregnancy and then dropping coverage soon after the baby was born, or of people scheduling elective surgical procedures 4 months out, signing up and again, dropping after their procedure.

Insurance rules (things like waiting periods & pre-existing conditions) are designed to prevent adverse selection. With more and more benefits being legislated, coverage's and waiting periods mandated by law, biotechnology and aging baby boomers, Mr. Actuarial thought, the future was looking rockier than the present.

APPENDIX B. Access to Care Data Book

Population-Demographics



DATA NOTES

- Thurston County is the eighth fastest growing county in the state of Washington in terms of number of people and percentage of population growth.
- Migration of people into the county, rather than births, accounts for the majority of the population increase.
- The racial and ethnic makeup of Thurston County is slowly becoming more diverse.
- The elderly population is the fastest growing segment of the population in Thurston County.
- Service sector jobs are forecasted to increase by 144% in Thurston County between 1990 and 2020 followed by construction at 105%.

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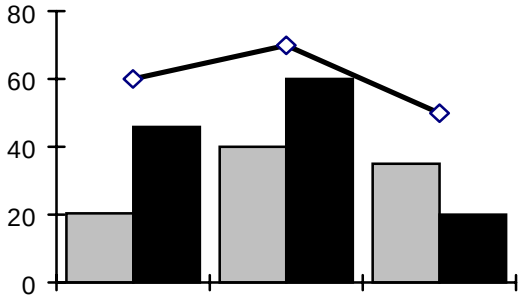
Health Status

Chronic Disease, Dental, Infectious Disease, Injury, And Pregnancy



DATANOTES

- Sixty-one percent of Thurston County two-year-olds were fully vaccinated for Diphtheria, Tetanus, Pertussis, Polio, Haemophilus influenzae B, Measles, Mumps and Rubella in 1998 compared to 49% in 1993.

- The 1998 Thurston County immunization survey showed a lower percentage of children receiving a Measles Mumps and Rubella (MMR) vaccination by age two than the 1993 survey in spite of media attention and multiple Measles outbreaks in adjacent counties.

- Pertussis is the most commonly reported vaccine preventable disease in Thurston County. The numbers of cases have increased across the state and in Thurston County over the past several years.

- The most commonly reported intestinal disease reported in Thurston County is Campylobacteriosis followed by Salmonellosis, Giardiasis, and E.coli O157H:7.

- Chlamydia is the most frequently reported sexually transmitted disease in Thurston County occurring most often in sexually active adolescents or young adults 15-29 years of age.

- The 1995 and 1996 Thurston County dental surveys found Thurston County children were 2 to 3 times more likely than Washington State children to have dental health problems like caries, rampant and untreated caries, need for treatment or urgent treatment and lack sealants.

- The 1996 Thurston County dental survey showed children currently or recently enrolled in Medicaid had more lifetime caries, rampant caries, baby bottle tooth decay, untreated caries, and were more in need of referral for dental care.

- Thurston County parents surveyed about their children's dental health in 1995 and 1996 reported having difficulty getting dental care for their children in the past 12 months. The most commonly cited problems were inability to find a dentist who would accept Medicaid, cost, and inability to find a dentist who would see children.

- The six leading causes of death in Thurston County in 1997 were cancer, coronary heart disease, diabetes-related deaths, unintentional injury, stroke, and chronic obstructive pulmonary disease including asthma.

- Chronic obstructive pulmonary disease deaths have increased in the past 15 years, particularly in women. This reflects past patterns of cigarette smoking.

- Unintentional injuries are the leading cause of death for individuals 1 to 44 years of age and account for the most years of loss of productive life.

- The health of mothers and infants are especially sensitive to poverty and other socioeconomic factors.

- Unintended pregnancies are highest among women whose household incomes are below poverty level (62%) compared to women with incomes above 185% of the federal poverty level (29%).

- Fifty-four percent of pregnancies to mothers with less than a high school education are unintended as compared to 33% unintended pregnancies to women with no more than a high school education.

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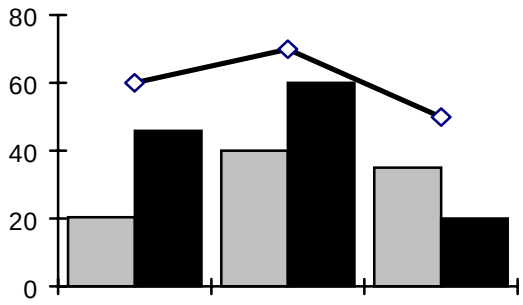
1996 THURSTON COUNTY BEHAVIOR RISK FACTOR SURVEY



DATANOTES

- The 1996 Thurston County Behavior Risk Factor Survey (TCBRFS) was a random digit dial phone survey of 500 Thurston County residents. It excluded data from households without phone service (approximately 97.5% of Thurston County residences have phones), collected self-reported information only, and gathered information from English speaking individuals no interpreters were used.

- Twelve percent of Thurston County residents interviewed for the survey reported they have no health care coverage.

- Twenty percent of those responding reported their coverage as Medicare.

- Ten percent of Thurston County residents interviewed indicated they could not see a doctor when they needed to in the past 12 months because of cost.

- The survey found 65% of those responding employed for wages or self-employed, 6% unemployed, 7% homemakers, 3.2% students, 17% retired, and 2.4% unable to work.

- Adults surveyed who were most likely not to have health insurance were individuals between the ages of 19 and 34.

- Fifty-three percent of Thurston County adults surveyed indicated they have smoked at least 100 cigarettes in their lifetime. Of those who have smoked at least 100 cigarettes, 34% now smoke everyday.

- Eight-two percent of Thurston County adults surveyed reported they had a usual source of medical care while 16% said they did not. More men than women had no usual source of medical care.

- Sixty-one percent of Thurston County Residents responding were overweight and 24% were obese according to calculated body mass indexes and categories established by the World Health Organization-National Institute of Health for Healthy People 2000.

- Forty-three percent of those surveyed reported they are trying to lose weight.

- Only 26% of Thurston County residents indicated they participate in physical activity or exercise 5 or more times per week.

- Eighty-seven percent of Thurston County women surveyed reported they had a Pap smear or test in the past 3 years.

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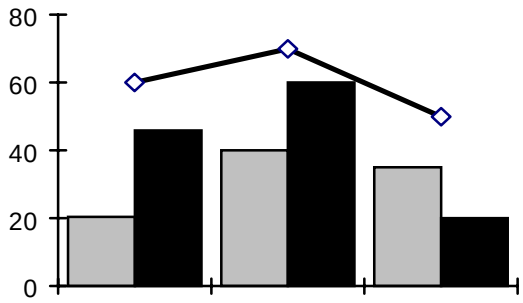
HEALTH CARE UTILIZATION



DATANOTES

- Clients seen at the Community Care Clinic have complex issues and are seen for serious problems as a result of seeking care late. They tend to come back many times for services.
- Community Care Clinic clients are most often individuals with no other connection to the health care delivery system.
- The Community Care Clinic typically sees more women than men. The exception was when the clinic operated as the Sojourner's Clinic an outreach clinic for the homeless in downtown Olympia resulting in an increased number of males accessing the facility.
- Historically, clients have sought care at the clinic for multiple problems most often respiratory, skin disorders, mental health and substance misuse issues, and infections.
- Most of the clients seen at the Community Care Clinic are residents of Thurston County.
- The 1997-1998 Emergency Room Assessment Project looked at 1996 emergency room data collected from billing information for a five county region including Thurston, Mason, Grays Harbor, Lewis and Pacific counties. Information collected was for individuals seen in the emergency room but not admitted. Data collected included demographics, payor source, and primary and secondary ICD9 codes.

- Visits to emergency rooms by males and females are evenly distributed according to the 1996 Emergency Room Assessment Project.

- Commercial insurance was most often used to pay for care received in emergency rooms followed by Medicaid (medical coupons). Health care practitioners involved in the study observed that the use of Medicaid may reflect the prevalence of poverty in the region. They also said people using Medicaid often do not identify a primary care physician and tend to use the emergency room more, which may reflect a lack of access to care and use of the emergency room for primary care.

- Individuals between 25 and 44 years of age are the largest age group in the region and seek care at emergency rooms more often than other age groups. Health care practitioners participating in the study believe this may be because they have no insurance or identified primary care provider and use the emergency room for primary care.

- The most common reason people visited the emergency room was for an injury that was a strain, sprain, or contusion, or abdominal or chest pain. The majority of individuals using the emergency room visited only once during the year.

- Females visiting the emergency room paid with Medicaid, were between 25 and 44 years of age, and were seen because of an injury that was a strain, sprain or contusion. Males paid with commercial insurance, were between 25 and 44 years old and had an injury that was a strain, sprain, or contusion.

- People visiting the ER who paid with Medicaid were somewhat more likely to visit more than once during the year. This might reflect a lack of access to primary care, poorer health associated with lower socioeconomic status, or other system-wide problem.

- People visiting the ER who paid with Medicare were more often females, 65 years of age or older. They visited once with diagnosis including chest or abdominal pain and injury that was a strain, sprain or contusion.

- Children (age 14 and under) seen in the emergency room most often paid with Medicaid, visited once, and were seen for respiratory problems or an injury that was either an open wound or contusion.

- There are two health care advice and referral lines open to the public in Thurston County. The lines are operated by the local hospitals and refer thousands of callers to local health care providers. Less than one fourth of physicians with hospital privileges participate in this referral system.

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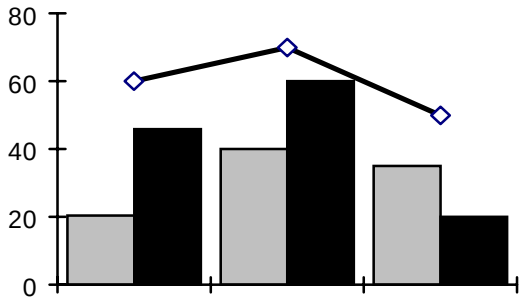
HEALTH INSURANCE MEDICAL AND DENTAL



DATANOTES

- Far fewer individuals have dental insurance than health insurance.
- Twelve percent of Thurston County adults surveyed for the 1996 Thurston County Behavior Risk Factor Survey reported they do not have health insurance.
- The number of uninsured Americans increased by 36% during the last decade.
- The lack of insurance correlates strongly with poverty. Six out of every ten uninsured individuals (57%) live in families with incomes less than 200 percent of the federal poverty level.
- More than six in every ten uninsured Americans live in families headed by a full-time worker.
- Key factors affecting health insurance coverage include individuals choosing not to purchase coverage because their incomes are low or because they believe their risks of needing health care are low. Individuals may or may not receive coverage from a public program as eligibility varies with income and other personal and household characteristics.

- Many employers choose not to provide health benefits because they face higher costs in doing so than their competitors and/or because their workforce doesn't strongly demand it.

- The primary reason for the increase in the number of Americans without health insurance over the past 15 years has been the increase of health costs relative to family income.

- Those most likely to reduce their purchase of health insurance are those with low family incomes and those with self-perceptions of low risk of needing health care services. In the labor market, those workers will seek out jobs where compensation is weighted toward cash and not health benefits.

- The actual costs of health insurance can be much higher for those unable to access employment-based health insurance. Work status of the family head can be an important factor in determining whether someone has health insurance coverage.

- Workers with the following job characteristics were most likely to be uninsured: the self-employed, those working in small businesses, those earning low wages, and part-time workers.

- The probability that an individual is uninsured decreases as the size of the firm that employs the family head increases. Wage earners are more likely to be uninsured if they work for establishments with less than 25 employees.

- Workers earning less than $10.00 per hour were at substantially greater risk of lacking health insurance than those earning $10.00 or more per hour.

- Ninety percent of the uninsured whose family head works for an employer with fewer than 10 employees also live in families whose income is less than 200 percent of the federal poverty level.

- The lower an individual's self-assessment of risk, the less likely he or she is to demand health insurance from the individual market or from employer-sponsored health plans.

- The rate of non-coverage decreases with age; older people are more likely to have some sort of health insurance.

- Women age 45 or older are more likely than men in their age cohort to be uninsured in spite of the fact they are also more likely to receive public coverage than men.

- Fifty-five percent of those responding to the January 1998 Washington Basic Health Plan Disenrollment Survey reported that their reason for disenrolling was the Basic Health monthly premium was too expensive. Twenty percent of respondents indicated their reason for disenrolling was they have insurance through their job or their spouse's job. Forty-four percent of respondents will either go without or are undecided about what they will do for coverage after leaving Basic Health.

- The increasing market penetration of managed care insurance plans has changed referral patterns and methods of health care service delivery.

- Over 52% of Washington residents receive health coverage through private or public sector employers, while publicly sponsored insurance (not tied to employment) provides coverage for almost one-third (31%) of all residents. The remaining 17% are on their own in the health insurance market most of whom are uninsured (11% of all state residents).

- Groups at high risk of being uninsured include racial/ethnic minorities (particularly Hispanic males), young adults ages 19-24, and people under 65 who were in good or fair health.

- Compared to people without health care coverage, insured people are more likely to have a regular source of medical care and to spend less out of pocket on health services.

- Insured and uninsured people experience different treatment patterns, quality, and continuity in their health care.

- Two national medical expenditure surveys found that an increasing number of workers are turning down job-based health insurance coverage. Reasons include higher cost compared to wages, higher employee contributions, and decreased benefits.

- Nationally, only slightly over half of all young adults ages 19-24 (53 percent) were covered by private health insurance.

- Among young adults ages 19-24, men and women were equally likely to have private insurance.

- Among minorities age 19-24, women were more likely than men to have public insurance, so more men were uninsured. In this age group, about 60 percent of all minority men were uninsured.

- Americans living in the West and South are more likely to lack a usual source of health care than those in the Northeast and Midwest.

- The main reasons reported for lacking a usual source of care included the following: seldom or never getting sick, having recently moved or not knowing where to go, and the cost of medical care. Hispanics, uninsured persons under age 65 and persons living in the West were more likely to report cost as the main reason for lacking a usual source of care.

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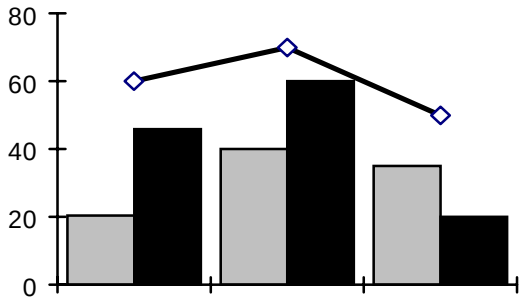
HEALTH CARE DELIVERY SYSTEM



DATANOTES

- National health care spending growth is expected to accelerate between 1998 and 2001, growing at an average annual rate of 6.5 percent. This compares to 5.0 percent average annual growth from 1993 to 1996.
- The slower growth in health care expenditures over the past few years was due mostly to slow spending growth in the private sector (2.9 percent), while public sector spending grew more quickly (7.5 percent).
- Between 1998 and 2001 this pattern is projected to reverse with private sector health expenditures growing at faster average annual rates (7.2 percent) than the public sector (5.7 percent).
- For the years 2001 to 2007, average annual growth is expected to be similar for both the private and public sectors.
- Patterns of growth in health care expenditures will differ substantially across types of services. While all health providers will be affected by rising costs, hospitals are expected to continue to face relatively slow growth in labor compensation as downsizing in this sector continues.

- Hospital growth is projected to increasingly lag behind growth in drugs, and physician and other professional services as the trend moves from inpatient to ambulatory care settings. This will be reinforced by the movement of Medicare beneficiaries into managed care. The rapid rise in outpatient hospital services will be tempered as the potential for further substitution for inpatient services declines.

- Expenditures for drugs are expected to grow at fairly rapid rates through 2007 as a result of rising utilization (number of prescriptions) and intensity (including changes in size and mix of prescriptions).

- Physicians who derive most of their practice revenue from managed care provide 40 percent less charity care than those who receive relatively little revenue from managed care plans.

- Physicians who practice in areas with high-managed care penetration provide less charity care than physicians in other areas, regardless of their own level of involvement with managed care.

- Low-income uninsured persons report lower access to care in areas with high Medicaid managed care penetration

- Differences in access between insured and uninsured persons – the so-called access gap – are even greater in areas with higher Medicaid managed care penetration.

- Primary care and reproductive health services are essentially the same for women between 18 and 44 years of age. Quality primary care must incorporate a full range of reproductive health services.

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